

**Joint Report to the
General Welfare, Health and Human Resources Committee
of the Senate,
Health and Human Resources Committee
of the House of Representatives, and the
Select Committee on Children and Youth**

**Report On the Status of
Emergency Medical Services for Children**

A Report to the 105th Tennessee General Assembly

**Tennessee Department of Health
September 2008**



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
227 FRENCH LANDING, SUITE 501
HERITAGE PLACE METROCENTER
NASHVILLE, TN 37243

BOARD FOR LICENSING HEALTH CARE FACILITIES
EMERGENCY MEDICAL SERVICES BOARD

September 4, 2008

The Honorable Rusty Crowe, Chair
Senate General Welfare, Health and
Human Resources Committee
321 War Memorial Building
Nashville, TN 37243

Dear Senator Crowe:

As required by Tenn. Code Ann §§68-11-251 and §68-140-521, we are pleased to submit the annual report on the Emergency Medical Services for Children (EMS-C) program; the Board for Licensing Health Care Facilities and the Emergency Medical Services Board collaborated with the Committee on Pediatric Emergency Care (CoPEC) in preparation of the report. The EMS-C program primarily focuses on pediatric pre-hospital and hospital care, with consideration for injury prevention, disaster preparedness, and quality improvement. This report reflects activities and accomplishments of the Board for Licensing Health Care Facilities and the Emergency Medical Services Board in meeting national EMS-C objectives.

Improving the availability and quality of children's health care is a major goal for the State of Tennessee and the Department of Health. Our boards help coordinate the major role of Tennessee's medical facilities and emergency medical services in providing appropriate pediatric emergency care.

Respectfully submitted,

Larry Arnold, M.D.

Original Signed By
Larry Arnold, M.D., Chairman
Board for Licensing Health Care Facilities

Robert L. Byrd, Jr.

Original Signed By
Robert Byrd, Jr., EMT-P, Chairman
Emergency Medical Services Board

cc: Susan R. Cooper, MSN, RN, Commissioner
Tennessee Department of Health



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BOARD FOR LICENSING HEALTH CARE FACILITIES
EMERGENCY MEDICAL SERVICES BOARD

September 4, 2008

The Honorable Joe Armstrong, Chairman
House Health and Human Resources Committee
21 Legislative Plaza
Nashville, TN 37243

Dear Representative Armstrong:

As required by Tenn. Code Ann §§68-11-251 and §68-140-521, we are pleased to submit the annual report on the Emergency Medical Services for Children (EMS-C) program; the Board for Licensing Health Care Facilities and the Emergency Medical Services Board collaborated with the Committee on Pediatric Emergency Care (CoPEC) in preparation of the report. The EMS-C program primarily focuses on pediatric pre-hospital and hospital care, with consideration for injury prevention, disaster preparedness, and quality improvement. This report reflects activities and accomplishments of the Board for Licensing Health Care Facilities and the Emergency Medical Services Board in meeting national EMS-C objectives.

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BOARD FOR LICENSING HEALTH CARE FACILITIES
EMERGENCY MEDICAL SERVICES BOARD

September 11, 2008

The Honorable Sherry Jones, Chair
Select Committee on Children and Youth
320 Sixth Avenue North
Rachel Jackson Building, 7th Floor
Nashville, TN 37243

Dear Representative Jones:

As required by Tenn. Code Ann §§68-11-251 and §68-140-521, we are pleased to submit the annual report on the Emergency Medical Services for Children (EMS-C) program; the Board for Licensing Health Care Facilities and the Emergency Medical Services Board collaborated with the Committee on Pediatric Emergency Care (CoPEC) in preparation of the report. The EMS-C program primarily focuses on pediatric pre-hospital and hospital care, with consideration for injury prevention, disaster preparedness, and quality improvement. This report reflects activities and accomplishments of the Board for Licensing Health Care Facilities and the Emergency Medical Services Board in meeting national EMS-C objectives.

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Larry Arnold, M.D., Chairman
Board for Licensing Health Care Facilities

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Emergency Medical Services Board

cc: Susan R. Cooper, MSN, RN, Commissioner
Tennessee Department of Health

Report on the Status of Emergency Medical Services for Children

Joint Report of
The Board for Licensing Health Care Facilities
And the
Emergency Medical Services Board
To the
Tennessee General Assembly
General Welfare Committee of the Senate
Health and Human Resources Committee of the House of Representatives
Select Committee on Children and Youth
On the Status of
Emergency Medical Services for Children

July 1, 2008

I. Requirement for Report

Tennessee Code Annotated 68-11-251 requires that the Board for Licensing Health Care Facilities and the Emergency Medical Services Board shall jointly prepare an annual report on the current status of emergency medical services for children and on continuing efforts to improve such services beginning July 1, 1999.

II. Trauma System Assessment

The Tennessee Department of Health (TDH) and its Division of Emergency Medical Services, located within the Bureau of Health Licensure and Regulation requested a trauma system consultation, which was conducted under the auspices of the American College of Surgeons, Trauma System Consultation program (TSC). The multidisciplinary site visit team (SVT) consisted of: two trauma / general surgeons, one emergency medicine physician, one state EMS director, a trauma system coordinator, a financial specialist, a rural trauma and pre-hospital specialist, and a pediatric and public health administrator.

RECOMMENDATIONS by the American College of Surgeons: The assessment had many recommendations for the adult system but stated, “Tennessee is to be commended for its national leadership in establishing a State wide inclusive system for provision of pediatric emergency care, including trauma care, “ The state needs to, “Begin the process of developing an inclusive statewide trauma system, building on the success of the inclusive pediatric regional network.”

Please refer to Appendix A for a report that contains frequency data for injuries in the Tennessee pediatric population defined as individuals < 14 years of age.

III. Commissioner’s Council on Injury Prevention and Surveillance (ICIPC)

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The American College of Surgeons also stated in their trauma assessment report that, “The state has successfully developed an extensive injury prevention coalition that includes partners from numerous state agencies, trauma centers, health professional organizations, health-related organizations, businesses, and voluntary organizations. The Committee on Pediatric Emergency Care (CoPEC) and Trauma Care Advisory Council (TCAC) have been actively engaged in the coalition and development of the state’s injury prevention strategic plan. The Health Commissioner’s Council on Injury Prevention and Control is a subcommittee of both TCAC and CoPEC.”

“Substantial progress in the development of an injury prevention and control program has been made as the recipient of a CDC capacity building grant. The state is currently in its third year of a five year grant. A significant product of this grant is the 2007 to 2010 Tennessee Injury Prevention Strategic Plan. The focus of the plan is on the continuing development of the infrastructure for implementation of the injury prevention program. Action steps for the implementation of the injury strategic plan have been defined, along with a timeline, responsible entity, partners, and potential funding needs. An injury prevention coordinator is funded by the CDC grant.”

“Three priority injuries have been selected for intervention: falls, motor vehicle crashes, and poisoning. These unintentional injuries are the leading causes of hospitalization for the majority of age groups, as well as a significant contributor to mortality. Future efforts will be devoted to identification of evidence-based injury interventions that can be implemented by coalition partners. Additional goals of the strategic plan include increasing the availability of data for planning, surveillance, and evaluation, as well as a focus on advocacy and public policy to reduce injuries.”

RECOMMENDATIONS from the American College of Surgeons and agreed upon by CoPEC

- Develop strategies to sustain the injury prevention program and injury prevention coordinator position once federal funding ends.
- Develop or maintain relationships with university or medical school public health programs so that continued epidemiology consultation is available to support future injury surveillance, data analysis, and injury intervention’s evaluation.
- Ensure that future deterministic and probabilistic data linkages are established between the EMITS, trauma registry, death records, and others databases such as FARS, and medical examiner reports to enhance the understanding of injury in the state.
- Create a supportive network that will assist coalition partners in addressing the identified priority injuries, implementing recommended evidence-based injury interventions, and evaluating outcomes.
- Provide information and education to policy makers and the public about the extent of the injury problem and the need for an inclusive trauma system as part of an injury prevention and control strategy.

IV. Pediatric Disaster Planning

Tennessee is a state that ranks 39th among the states with 21.7% of the pediatric population and 25% of children under age 5 living in poverty (2004 census estimates). If the poverty level is used as a proxy for access to resources such as transportation in the event of a disaster, this pediatric population could be devastated. It is important to understand that the developing minds and bodies of infants and children already place them at a disproportionate risk of harm. Examples include:

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- 1) Their understanding of events will depend on their developmental, not their chronologic age.
- 2) Separation from family members or care takers presents a supervision problem for rescuers and can create unique challenges for identification and tracking.
- 3) Children do not have the cognitive decision-making skills to understand they need to run from the danger or to follow instruction given by others.
- 4) Children have less fluid reserve than adults and can become dehydrated faster if they come into contact with agents that produce vomiting and/or diarrhea.
- 5) Children have thinner skin and a larger surface-to-mass ratio than adults. This makes them more prone to hypothermia and more sensitive to some percutaneously absorbed toxins due to enhanced permeability.
- 6) Children can change rapidly from a stable to life-threatening condition because they have less blood and fluid reserves. Assessment of these patients can be challenging to inexperienced providers.
- 7) Children are more sensitive to changes in body temperature and have a faster metabolism than adults. Some toxins may act more rapidly in children and the dosing of medications can be markedly different than adults.
- 8) Children have a smaller circulating blood volume than adults making them more vulnerable to irreversible shock or death.
- 9) Children are particularly vulnerable to aerosolized biological or chemical agents because their more rapid respiratory rate may lead to increased uptake of an inhaled toxin. Also some agents (i.e. sarin and chlorine) are heavier than air and accumulate close to the ground – right in the breathing zone of children.
- 10) Medication dosing for children is based on weight and/or body surface area whereas with adults there is typically a standard dose for a medication regardless of age. Children are therefore more prone to medication dosing errors by inexperienced health care providers who do not take weight based dosing into account. Children also require equipment specifically designed to meet their anatomic and physiologic requirements.
- 11) Rescuers and other health care providers may have little experience in treating pediatric patients and may have emotional difficulty dealing with severely injured infants and children. Providers not familiar with many of the unique anatomic and physiologic aspects of pediatric trauma, such as unique patterns of head injury, cervical spine injury, and abdominal injuries, may make assessment and treatment errors.

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Because of these unique features, pediatric patients pose special challenges to rescuers and other health care providers- many of whom are unfamiliar or uncomfortable treating children. Tennessee's disaster preparedness plan must take these factors into account including the special skills, equipment, knowledge and training required to protect, treat and safeguard the future of our pediatric populace.

A Pediatric Disaster Preparedness Toolkit was completed to allow physicians, nurses, pre-hospital personnel as well as the public to learn how to prepare and react in the event of a disaster. On line modules at www.tnemsc.org include:

- Responding to Bioterrorism and the Pediatric Patient
- Responding to Chemical Warfare and the Pediatric Patient
- Explosion and Blast Injuries and the Pediatric Patient
- Responding to Radiation Disasters and the Pediatric Patient
- Children with Special Needs: Considerations for the Healthcare Professional
- Family Preparedness
- Family Preparedness Supplement: Children with Special Needs

Also created is a flip chart with pediatric resuscitation guidelines and information on the above referenced disasters occurring in a clinical setting. Flip charts were distributed to every ambulance and acute care hospital in the state.

RECOMMENDATIONS from CoPEC

- Drills and management in rural areas need to be improved and incorporate pediatric patients.
- Development and management of disaster needs for special needs children needs to be improved.
- We need a more dedicated focus from each of the Comprehensive Regional Pediatric Centers in relation to disaster especially regarding special needs children

V. National Performance Measures

Health Resources and Services Administration (HRSA) has delineated a specific set of measurements that will:


- Provide an ongoing, systematic process for tracking progress towards meeting the goals of the EMS C Program;
- Allow for continuous monitoring of the effectiveness of key EMS C Program activities;
- Identify potential areas of performance improvement among the EMS C State Partnership grantees;
- Determine the extent to which the grantees are meeting established targets and standards; and
- Allow the EMS C Program to demonstrate its effectiveness and "tell its story" to HRSA, Congress, and other stakeholders.

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Therefore, HRSA has developed three performance measures as outlined below

PERFORMANCE MEASURE #66	The degree to which State/Territory has ensured the operational capacity to provide pediatric emergency care.
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Listed below indicates the progress Tennessee EMSC has made towards ensuring operational capacity to provide pediatric emergency care (Performance Measures #66a, #66b, #66c, and #66d) and whether TN has met the target for each element of operational capacity.

Performance Measure	Target Met	Description of Evaluation of Performance Measure
<p>A. The percentage of pre-hospital provider agencies that have on-line and off-line pediatric medical direction at the scene of an emergency for:</p> <ul style="list-style-type: none"> ▪ BLS providers ▪ ALS providers 	<p>Basic Life Support & Advanced Life Support ambulances have 100% off-line pediatric medical direction</p>	
<p>B. The percentage of pre-hospital provider agencies that have the essential pediatric equipment and supplies as outlined in the American Academy of Pediatrics & the American College of Emergency Physicians Joint Guidelines for:</p> <ul style="list-style-type: none"> ▪ BLS ambulances ▪ ALS ambulances 	<p>Basic Life Support & Advanced Life Support ambulances have 100% of the essential equipment required by rules and regulations</p>	<p>In the process of presenting new recommendations to the EMS Board</p>

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<p>C. The existence of a statewide, territorial or regional system that recognizes hospitals that is able to stabilize and/or manage pediatric emergencies.</p>	<p>TN state legislature unanimously passed the TN EMSC legislation in 1998. In response to the legislation and CoPEC recommendations, the Board for Licensing Health Care Facilities has promulgated rules and regulations to ensure compliance with the law. These rules include a requirement to promote regionalization of a family focused approach to the care of the child and pediatric equipment and education requirements for nurses and physicians.</p>	<p>Achieved</p>
<p>D. The percentage of hospitals that have written inter-facility transfer agreements that specify alternate care sites that have the capabilities to meet the clinical needs of critically ill and injured pediatric patients and inter-facility guidelines that specific to the performance measure.</p>	<p>100 % of hospital facilities in TN have written inter-facility agreements</p>	<p>Partially Achieved</p> <p>The agreements do not specify all four components listed in the national objective. A task force is being developed with the TN Hospital Association and the Comprehensive Regional Pediatric Centers (LeBonheur, Vanderbilt, TC Thompson, and ETCH) to make recommendations.</p>

PERFORMANCE MEASURE #67

The adoption of requirements by the State/Territory for pediatric emergency

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education for the recertification of paramedics.

TN state legislature unanimously passed the TN EMSC legislation in 1998 requiring pediatric emergency education. TN also participates in the National Registry of EMT. Tennessee has not adopted requirements for pediatric emergency education for the recertification of paramedics by rules and regulations but is working with the State Committee on Pediatric Emergency Care and the State EMS Board to remedy this.

PERFORMANCE MEASURE #68

The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system.

The table below indicates the progress Tennessee EMSC has made towards establishing the permanence of EMS C in the State/Territory EMS system (Performance Measures #68a, #68b, #68c, and #68d) and whether TN has met the target for each element of permanence.

Performance Measure	Target Met	Description of Evaluation of Performance Measure
<p>A. The establishment of an EMS C Advisory Committee within the State/Territory.</p>	<p>TN state legislature unanimously passed the TN EMSC legislation in 1998 creating a standing Committee on Pediatric Emergency Care (CoPEC) which reports to both the Board for Licensing Health Care Facilities (BLHCF) and the Emergency Medical Services Board (EMSB). Family and community members are active partners in TN EMSC/CoPEC. Parent representation includes the TN Chapter of Family Voices and the Parent Teacher Association (PTA). Individual parent and community members also participate in our activities at the state and local level.</p>	<p>Achieved</p>

Report on the Status of Emergency Medical Services for Children

	<pre> graph TD DOH[Department of Health] --> BLHCF[Board for Licensing Health Care Facilities] DOH --> EMSB[EMS Board] BLHCF --> TCACT[Trauma Care Advisory Council] EMSB --> CoPEC[CoPEC] </pre>	
<p>B. The incorporation of pediatric representation on the State/Territory EMS Board.</p>	<p>CoPEC reports to the State EMS board and the Board for Licensing Health Care Facilities.</p>	<p>There is not currently a pediatric representative on the state EMS Board, but the national performance measures may be modified to delete this requirement.</p>
<p>C. The establishment of an in-State/Territory-funded full time equivalent (FTE) for an EMSC Coordinator that is dedicated solely to the EMSC Program.</p>	<p>TN has 1.5 FTE’s dedicated solely to the state EMSC program.</p> <p>TN also has four comprehensive regional pediatric coordinators that are funded by the children’s hospitals in the state.</p>	<p>The 1.5 are funded by federal grant monies that are on a year to year funding cycle.</p> <p>Achieved</p>
<p>D. The integration of EMSC priorities into existing EMS statutes/regulations</p>	<p>Performance measures:</p> <p>66 b, c, d</p> <p>67</p> <p>68 a ,c</p>	

VI. The Needs of the State Committee on Pediatric Emergency Care

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Expanding the scope of services for CoPEC to include the entire EMS-C continuum of care as defined by the Federal EMS C program will greatly enhance CoPEC's ability to assist the Department of Health in meeting the emergency needs of critically ill and injured children.

- Funding to support the necessary expenses of the CoPEC members for travel and subsistence while attending meetings to provide the expertise required by the Public Chapter 599. Since 1994, members have provided their own travel and subsistence funding.
- Support from the Department of Health to accomplish the following goals for the upcoming year.

VII. Plans for next year

The plan for CoPEC is to continue to advise the Board for Licensing Health Care Facilities and Emergency Medical Services Board in promulgating regulatory standards to ensure the adequacy of emergency medical services for children.

These plans will include at a minimum:

- Stakeholders in the Emergency Medical Services for Children program will encourage
 - The inclusion of pediatric components to the state disaster plan. Currently, the statewide plan for disaster readiness for pediatrics has not been established.
 - Drills and management in rural areas need to be improved and incorporate pediatric patients.
 - Development and management of disaster needs for special needs children needs to be improved.
- Work with the TN Hospital Association, Children's Hospital Alliance of TN to develop a statewide template for inter-facility agreements that contain the national performance measure components.
- Facilitate and coordinate an EMS C quality improvement program
- Continue to increase and standardize communication among providers, facilities, and committee members

VIII. Conclusion

The Board for Licensing Health Care Facilities and the Emergency Medical Services Board work cooperatively with other programs of the Department of Health to improve the quality of health care and medical services available to the citizens of Tennessee. We have met the challenge to adopt regulatory standards to respond to the need for adequate emergency medical care for children.

We hope to further describe the impact of the rules on pediatric emergency care by utilizing data collected in the Department of Health in our next report due July 1, 2009.

This report was reviewed by the members of the respective boards and approved for presentation to the designated committees of the Tennessee General Assembly on August 27, 2008.

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Appendix A: Data Relative to Emergency Medical Services for Children

This report contains frequency data for injuries in the Tennessee pediatric population defined as individuals < 14 years of age. The data source, provided through the Division of Health Statistics at the Tennessee Department of Health, is hospital discharge data for the years 2000 through 2005. Therefore, this report reflects Tennessee children admitted to Tennessee licensed hospitals (inpatient, emergency department visits, and other outpatient visits). Consequently, it should be noted that these data do not include children visiting their primary care provider or did not seek any care. The standards of coding and reporting followed were from the “Consensus Recommendations for Using Hospital Discharge Data for Injury Surveillance (Injury Surveillance Workgroup, Marietta, GA: State and Territorial Injury Prevention Directors Association, 2003).

Case selection for analysis was based on the principal diagnosis code (PDC) and external cause code (E-code). Principal diagnosis codes between 800 and 999.9 represent injury and poisoning (ICD-9-CM international classification of diseases, Physician, volumes 1 and 2, 9th revision-Clinical Modification, American Medical Association, Chicago, IL, 2007). Exclusions within this range included late effects of complications due to surgery, medical care, drugs and biologic agents (909.3, 909.5); other anaphylactic shock, unspecified adverse effects of drugs, biological substances, adverse food reaction, anesthetic adverse reactions, unspecified allergy and angioneurotic edema (995-995.4, 995.6 – 995.7, 995.86, 995.89), and complications to specified procedures (996-999). Among this subset of injury related PDC, E-codes were classified according to the recommended framework of E-code groupings for presenting injury mortality and morbidity data (“Consensus Recommendations for Using Hospital Discharge Data for Injury Surveillance, Injury Surveillance Workgroup, Marietta, GA: State and Territorial Injury Prevention Directors Association, 2003).

For reporting purposes, patient age (years) was categorized into <1, 1 to 4, 5 to 9, 10 to 12, and 13 to 14. Injury frequencies are listed across rows of tables with the row header “Number of Events”. There are two “Percent of ...” row headers. The denominator of the first of these percent data is the sum of events over (across) columns. The denominator of the second “Percent of ...” row header is the sum of events over (down) rows. The overall number of injuries reported here are 789,788.

Summary Findings:

1. The number of discharges for pediatric trauma is stable over the study period. Mortality for pediatric trauma is steady at 0.04% with 301 deaths over the six year period. There are fewer deaths in 2005 (42) than any other year but it is unclear whether this fact represents a trend. (Table 1)
2. Since 2000, the year EMSC was first launched in TN, between 23 and 25% of pediatric traumas receive their care in a CRPC. This is a statistically significant and stable trend. (Table 2)
3. Children with an Injury Severity Scores (ISS) > 10 (which indicates a sicker patient) received their care in a CRPC 47% of the time, compared to 23% when the ISS was < 10. (Table 3)
4. Children with an ISS > 10 had a 5.3% mortality rate compared with 0.02% mortality for those with an ISS < 10. Points 3 and 4 suggest that the system is

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good at keeping stable children in smaller hospitals but needs to improve on getting sicker children to the CRPC's more consistently since they have a much greater risk of dying..

5. For every point increase in ISS, the child's risk of death increases by 5.3% (odds ratio 1.053, 95% confidence interval 1.048 to 1.057), but the likelihood of receiving care at a CRPC only increases by 1.1% (odds ratio 1.011, 95% confidence interval 1.010 to 1.013). This finding reinforces the idea that sicker patients are still receiving care in the absence of subspecialists.
6. For years 2000 to 2005, the percentage of children discharged from medical care with an ISS > 10 has been from 0.39 to 0.86. That same group comprises between 30 to 61% of the mortality. (Tables 4-9)

Table 1: death by year							
death	year						Total
Frequency Percent Row Pct Col Pct	2000	2001	2002	2003	2004	2005	
No	127433 99.96	132383 99.97	131243 99.96	132492 99.96	134969 99.96	130967 99.97	789487 99.96
Yes	46 0.04	46 0.03	55 0.04	56 0.04	56 0.04	42 0.03	301 0.04
Total	127479 16.14	132429 16.77	131298 16.62	132548 16.78	135025 17.10	131009 16.59	789788 100.00

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Table 2: crpc usage by year							
	year						
Frequency Percent Row Pct Col Pct	2000	2001	2002	2003	2004	2005	Total
No CRPC	99844 78.32	101901 76.95	101332 77.18	101376 76.48	103557 76.69	100358 76.60	608368 77.03
CRPC	27635 21.68	30528 23.05	29966 22.82	31172 23.52	31468 23.31	30651 23.40	181420 22.97
Total	127479	132429	131298	132548	135025	131009	789788 100.00

Table 3: crpc usage byISS			
	ISS		
Frequency Percent Row Pct Col Pct	ISS<10	ISS>=10	Total
No CRPC	606232 76.76 99.65 77.15	2123 0.27 →0.35% 53.19	608355 77.03
CRPC	179552 22.73 98.97 22.85	1868 0.24 →1.03% 46.81	181420 22.97
Total	785784 99.49	3991 0.51	789775 100.00
Frequency Missing = 13			

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Table 4: death by ISS, yr 2000			
death	ISS		
Frequency			
Percent			
Row Pct			
Col Pct	ISS<10	ISS>=10	Total
No	126344	1079	127423 99.96
Yes	32 69.57	14 30.43	46 0.04
Total	126376 99.14	1093 0.86	127469 100.00
Frequency Missing = 10			

Table 5: death by ISS, yr 2001			
death	ISS		
Frequency			
Percent			
Row Pct			
Col Pct	ISS<10	ISS>=10	Total
No	131808	574	132382 99.97
Yes	18 39.13	28 60.87	46 0.03
Total	131826 99.55	602 0.45	132428 100.00
Frequency Missing = 1			

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Table 6: death by ISS, yr 2002			
death	ISS		Total
Frequency Percent Row Pct Col Pct	ISS<10	ISS>=10	
No	130707	534	131241 99.96
Yes	31 56.36	24 43.64	55 0.04
Total	130738 99.58	558 0.42	131296 100.00
Frequency Missing = 2			

Table 7: death by ISS, yr 2003			
death	ISS		Total
Frequency Percent Row Pct Col Pct	ISS<10	ISS>=10	
No	132002 99.59 99.63 99.98	490 0.37 0.37 94.78	132492 99.96
Yes	29 0.02 51.79 0.02	27 0.02 48.21 5.22	56 0.04
Total	132031 99.61	517 0.39	132548 100.00

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Table 8: death by ISS, yr 2004			
death	ISS		Total
Frequency Percent Row Pct Col Pct	ISS<10	ISS>=10	
No	134392	577	134969 99.96
Yes	24 42.86	32 57.14	56 0.04
Total	134416 99.55	609 0.45	135025 100.00

Table 9: death by ISS, yr 2005			
death	ISS		Total
Frequency Percent Row Pct Col Pct	ISS<10	ISS>=10	
No	130377	590	130967 99.97
Yes	20 47.62	22 52.38	42 0.03
Total	130397 99.53	612 0.47	131009 100.00